

(Provider completes)

## North Carolina Division of Medical Assistance Notice of Case Status

Enter Name and Address of County DSS

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Please determine whether the patient is eligible for medical assistance under Title XIX Medicaid. Use the reverse side of notify us of your decision.

1. Patient's Name (First, Mi, Last)		2. Telephone number	
3. Address			
4. Date of Birth	5. Social Security Number	6. Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	
7. Spouse's Name			
8. Parent's/Guardian's Name (Give only if patient is a minor child)			
9. Inpatient Hospital Admission Date: _____Month _____ Day 20_____Year			
10. Estimated Discharge Date: _____Month _____ Day 20_____Year			
11. Daily Charges-to-Date: _____Attached _____ Will be provided upon discharge.			
_____ Name of person completing form		_____ Date	_____ Title
Provider's Name and Address		Telephone Number	
Consent of Patient/Parent/Guardian to referral			
_____ Signature		_____ Date	_____ Relationship to Patient

### Instructions

#### 1. Provider:

- Do not make this referral without the knowledge or consent of the patient and/or his family.
- Prepare original and one copy. Send original to the county DSS and retain the copy for your files.

#### 2. County:

See reverse side of this form for detailed instructions.

DMA-5020  
Revised 10/01/02

## North Carolina Division of Medical Assistance

## Notice of Case Status

\_\_\_\_\_County Department of Social Services

Enter name and Address of Provider

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1. Name: (First, MI, Last)		
2. Individual ID Number	3. Aid Program/Category	4. Classification Code
5. This response acknowledges receipt of your referral and informs you of the status:		
a. <input type="checkbox"/> Medicaid authorization begins on: _____ Patient payment due hospital: \$ _____		
b. <input type="checkbox"/> An application has been filed and is being processed. You will be notified when the decision is made.		
c. <input type="checkbox"/> We are waiting for the applicant/recipient to return necessary information to make a determination of eligibility.		
d. <input type="checkbox"/> Medical information required to establish incapacity has not been returned from the patient's doctor. Form DMA-5006 is attached for completion. Please return to this office when completed.		
e. <input type="checkbox"/> The individual was notified on _____ to come to the agency to file an application for Medicaid.		
f. <input type="checkbox"/> Patient is not eligible for Medicaid.		
6. Carolina ACCESS <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Care Provider is _____ (Name)		
County Director Signature /Designee		Date

Instructions: County Department of Social Services

- A. Within 15 workdays after receipt, complete status information. Return original to the provider and retain a copy for your file.
1. If the patient is eligible, enter the Medicaid ID number in block 2.
  2. If the individual is eligible for dates of hospitalization, check block 5.a. and enter authorization from date.
  3. If the case has a deductible, enter in block 5.a., the amount of the deductible balance applied to the hospital charges on date of authorization. This amount must agree with the deductible balance amount entered in EIS.
- B. If block 5.b.c.d.or e. is checked, notify the provider of the final disposition via copy of the file with the disposition status entered.
- C. **Use this form to notify the hospital of the deductible amount due the hospital for any hospitalized recipient whether or not hospital has initiated referral.**